CENTENE® Corporation

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity
Entity: DBA Name:
Address:
Federal Tax Identification Number:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ■ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ■ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ■ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ■ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form by fax to (*insert Fax #*) or by mail in the enclosed postage paid envelope to:

(*insert Address here*)

Practitioner Data Form

silversummit healthplan

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING THE ADDITIONAL DOCUMENTS LISTED BELOW SO THAT WE MAY PROCESS YOUR REQUEST. *This form includes Personally Identifiable Information (PHI) such as practitioner name, date of birth and SSN and should be sent in a secure manner.*

- ☐ Provider's W-9 (one per tax entity)
- ☐ Ownership and Disclosure form
- ☐ Behavioral Health Providers: Behavioral Health Addendum
- ☐ Documentation of board certification or scheduled exam date
- ☐ Supplemental sheet for additional locations
- ☐ Completed Provider Assessment of Cognitive and Physical Disabilities and Accommodations tool (one per location)

INDIVIDUAL PRACTITIONER

Practitioner Name and Degree
[Last] [First] [MI] [Degree]

Practitioner has CAQH? ☐ YES ☐ NO
CAQH #:

DOB

Gender ☐ Female ☐ Male

Preferred Pronouns (optional):

Practitioner Type
☐ PCP ☐ OBGYN ☐ Specialist ☐ Intern ☐ Other _____

Requested Effective Date

Line of Business
☐ Medicaid ☐ Medicare ☐ Commercial

Hospital-based Only? ☐ YES ☐ NO

Participating in Medicaid? ☐ YES ☐ NO ☐ Pending

Participating in Medicare? ☐ YES ☐ NO ☐ Pending

SSN | Individual NPI # | Medicaid ID # | Medicare ID #

License # State Exp Date

DEA# State Exp Date ☐ N/A

Primary Practicing Specialty | Specialty Taxonomy *(must match NPPES)* | Board Certification: ☐ YES ☐ NO Date of Exam:

Secondary Practicing Specialty | Specialty Taxonomy *(must match NPPES)* | Board Certification: ☐ YES ☐ NO Date of Exam:

Accepting New Patients
☐ YES
☐ YES, Existing Patients Only
☐ Have a Waitlist
Average wait time_____
☐ NO

Patient Gender Restrictions
☐ None
☐ Female Only
☐ Male Only

Ages Treated Restrictions
☐ None
☐ Age Limits
Min Age: _____
Max Age: _____

Ages treated for Psychiatrists/ Psychologists who treat child/adolescent
☐ 0-6 ☐ 7-12
☐ 13-17 ☐ 18-21

Do you offer integrated physical and behavioral health care? ☐ YES ☐ NO ☐ N/A

Any **PCP** panel size and restrictions (accepting referrals only, etc) ☐ YES ☐ NO
If YES, please explain:

Visit by ☐ Telemedicine ☐ In-person ☐ Both

Do you provide services to individuals with special needs/chronic conditions? *(check all that apply)*
☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None

Do you provide services/accommodations to individuals who have difficulty communicating or cooperating (i.e., those with autism or intellectual disabilities)? ☐ YES ☐ NO

Do you provide services to individuals with mobility limitations (i.e., wheelchair bound)? ☐ YES ☐ NO

Do you treat any of the following diagnoses? *(check all that apply)*
☐ Anxiety ☐ AHDS ☐ EPSDT ☐ Depression ☐ HIV ☐ Substance Abuse ☐ None

Which evidenced based practices are you or your staff training on or actively using in your clinical practice?
☐ Trauma informed care ☐ Dialectical behavior therapy (DBT) ☐ Eye movement desenzitation and reprocessing (EMDR) ☐ None of the above

PCPs and OBs ONLY: Do you provide any of the following services? ☐ EPSDT ☐ OB ☐ None

PROVIDER GROUP

W-9 Registered Name (Required)

Group Practice Name (DBA) if applicable

Group Type *(check all that apply)*
☐ FQHC/RHC ☐ IC
☐ Multi-Specialty
☐ Other_____

BILLING (PAY TO) INFORMATION

Billing Contact Name			
Address			Phone #
City	State	Zip Code	Fax #

PRIMARY ADDRESS *(Physical location where services are performed)*

Address				City		State	
Zip Code		County		Phone #		Fax #	
Office Hours	DAY	OPEN	CLOSE	DAY	OPEN	CLOSE	☐ Supplemental sheet attached for additional addresses
	Monday			Friday			
	Tuesday			Saturday			
	Wednesday			Sunday			TIN:
	Thursday						Group NPI:
List Practitioner in Directories at this address? ☐ YES ☐ NO							

OFFICE CONTACT

Name/Title	Phone #		Fax #
Email	Practice Website		
Address	City	State	Zip Code

CREDENTIALING CONTACT

Name/Title	Phone #		Fax #
Email			
Address	City	State	Zip Code

Languages other than English spoken by PRACTITIONER

Languages other than English spoken by OFFICE STAFF

Race Ethnicity

☐ Black/African ☐ Hispanic/Latino/Spanish ☐ Asian
☐ Native American/American Indian ☐ Native Hawaiian ☐ White/Caucasian
☐ Prefer not to disclose ☐ Pacific Islander
☐ Other (please add) _____

ADDITIONAL PRACTICE LOCATIONS *(Physical location where services are performed)*

Address				City		State	
Zip Code		County		Phone #		Fax #	
Office Hours	DAY	OPEN	CLOSE	DAY	OPEN	CLOSE	
	Monday			Friday			
	Tuesday			Saturday			
	Wednesday			Sunday			TIN:
	Thursday						Group NPI:
List Practitioner in Directories at this address? ☐ YES ☐ NO							

ADDITIONAL PRACTICE LOCATIONS *(Physical location where services are performed)*

Address				City		State	
Zip Code		County		Phone #		Fax #	
Office Hours	DAY	OPEN	CLOSE	DAY	OPEN	CLOSE	
	Monday			Friday			
	Tuesday			Saturday			
	Wednesday			Sunday			TIN:
	Thursday						Group NPI:
List Practitioner in Directories at this address? ☐ YES ☐ NO							

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	Zip Code		County			Phone #		Fax #
	Office Hours	**DAY**	**OPEN**	**CLOSE**	**DAY**	**OPEN**	**CLOSE**	
		Monday			Friday			
		Tuesday			Saturday			
		Wednesday			Sunday			TIN:
		Thursday						Group NPI:
	List Practitioner in Directories at this address?				☐ YES	☐ NO		

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		Monday			Friday			
		Tuesday			Saturday			
		Wednesday			Sunday			TIN:
		Thursday						Group NPI:
	List Practitioner in Directories at this address?				☐ YES	☐ NO		

PRACTITIONER LOCATION ADDRESS			
Accomodation	**YES**	**NO**	**NA**
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limittions or wheelchair bound			
Flexible appointment times available - sick appointments, same day appointments - please specify			
Assistance available to members to fill out forms			
In-home and/or community services			
Large print materials			
Materials in electronic format			
Augmentative/alternative communication devices			
American Sign Language translator			
Signage in Braille and raise tactile text characters at office, elevator stairwells, and restroom doors mounted 60in from floor			
Visible and audible alarms - emergency systems			
Railings between 30 and 38in high on both sides			
Paths are at least 36in wide and free of protruding objects			
Cane detectible objects on ground as a warning barrier			
Widened doorways (at least 32in clearance)			
Lever or loop handles vs knobs			
5ft circle or T-shaped space for turning a wheelchair completely			
A clear floor space, 30"x48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer			
Adjustable height exam table or chair (lowers to 17-19in from floor)			
Celing or floor based patient lift			
Wheelchair accessible scales			
Adjustable height radiologic equipment			
Handicap parking			
Handicap accessible restroom			
Access ramps			
Accessible by bus			
Accessible by Valley Metro Rail			
Provider/Staff has completed cultural competence training			
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than a Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)			
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)			

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*